DOCUMENT RESUME

ED 085 433 UD 013 906

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TITLE The Nursing Profession and the Urban Poor. NCRIEEO Tipsheet, Number 11, April 1973.
INSTITUTION Columbia Univ., New York, N.Y. National Center for Research and Information on Equal Educational Opportunity.
SPONS AGENCY Bureau of Elementary and Secondary Education (DHEW/OE), Washington, D.C. Div. of Equal Educational Opportunities.
PUB DATE Apr 73
NOTE 4p.

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Cultural Factors; *Economically Disadvantaged; Economic Disadvantagement; Health Education; Health Facilities; Medical Education; *Medical Services; Nurses; *Nursing; Perception; Poverty Research; *Research Needs; Social Change; Teacher Nurses; *Urban Population

ABSTRACT

The paucity of research and writings about nursing and the urban poor seems to indicate that the nursing profession has not yet analyzed and evaluated itself in this regard. If so, the nursing leadership has accepted its share of the challenge to improve the capabilities of practitioners who work with the poor without having assessed the effectiveness of its practitioners or its curriculum in the delivery of health care to the poor. There are some direct clues in the writings of non-nurses that nurses' perceptions of urban poverty should be further studied. No studies were located, for example, which examined the perceptions of associate degree nurses regarding the life situations of the urban poor population, although there are several reasons why it would be an appropriate group to study. Those left out of the mainstream of society have developed adaptations of values. Attention to such life styles should tell a good deal about how and why certain groups are excluded from the mainstream and are unable to obtain adequate services. These insights can guide officials and planners to see that education, health, and social service techniques and delivery modes must be restructured if they are to be equally available to the disadvantaged poor. (Author/JM)

NCRIEEO TIPSHEET #11

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The Nursing Profession and the Urban Poor

by Doris Y. Mosley

Today's urban educators face serious challenges from the communities which they purport to serve. Teachers and administrators have been selected for castigation for a number of years. But as the disharmony between school and community continues and escalates, other helping professions now face similar challenges. They include those persons who facilitate the teaching–learning process: guidance and recreational personnel, rehabilitation counselors, school nurses, social workers and health educators.

School health services have been historically least susceptible but socially most vulnerable to community criticism. In many respects, school health services have failed to realize their aims: helping each pupil attain and maintain the highest possible level of health; providing educational experiences aimed at the development of sound attitudes toward health; fostering practices designed to help each pupil become more self-reliant in maintaining and improving his own health and that of others; and, promoting healthy and safe school environments.

Nursing Students' Perceptions of the Urban Poor

Despite the long-standing and well-known commitments of the health professions to the "public," serious problems exist in the delivery of sufficient and coordinated health care. Today the discontent of the affluent sector manifests itself in political action for change, and writers describe the situation as "chaotic,"[1] and a "non-system."[2]

But there is another segment of the public which is beginning to be heard. They are the poor who have been neglected, rendered invisible, and left behind in the affluent advance of America. The poor have had few influential spokesmen to make known their situation. In this communication vacuum, it became an accepted opinion among many health professionals that health facilities for the poor were adequate, but were not utilized due to apathetic and uncooperative behavior.[3] However, the same rapid communication has enabled the poor to become aware of the affluence of other segments of society and of their own relative deprivation. Now that the poor and their socially conscious spokesmen complain of racial and cultural discrimination, it is difficult for health professionals to pass the buck. Although national morbidity and mortality statistics of the poor are considerably less alarming than those of "underdeveloped" countries, when these statistics are compared to the American health potential, they have led some observers to label the health care of this group a "crisis,"[4] an "ongoing national disaster,"[5] and a "national disgrace."[6]

The health professions are responding to these challenges. Pressured by political and other interest groups, hampered by intraprofessional disagreements and communication gaps, puzzled by conflicting values and working against time, they are attempting to chart a new path to greater commitment to those in need of service. This they share in

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common with other major American service institutions.

Unlike American medicine, nursing is a health profession with an early and definite commitment to the indigent sick. Its very emergence in America was a vigorous response to deplorable conditions in municipal hospitals. Events and circumstances would seem to have changed the priorities in nursing since then. There is growing evidence that the nurse practitioner is too often ineffective in her work with the urban poor. This seems a paradox when it is known that the nursing curriculum provides for the study of sociology, psychology, and other supportive courses which will enhance understanding of the "patient as a whole." However, a group of health science students states that:

> The nature of poverty and its effect on the patient, even on the disease itself, has been neglected. The products of such an education are physicians, nurses, and dentists who are skilled in the techniques of their professions, but who are woefully ignorant of the sociological factors which affect the lives of their patients.[7]

There are other nurse practitioners in successful antipoverty work who would agree with these students.

Most writers agree that there is a complex set of interrelated factors affecting health care of the poor. Among them are heredity, environmental conditions, socioeconomic factors, attitudes toward health care, and the distribution and availability of health services and facilities. But certain barriers to the delivery of health care to the poor have also been identified:

1. Inability to pay, including the humiliation of "means tests" which establish medical indigence necessary to receive so-called "free care."

2. Fragmentation of care; the depersonalization and confusion of referral to various medical specialty clinics. This is well illustrated by an example of an elderly indigent patient with 12 major diagnoses for which he was required to attend 10 clinics. He was too ill to do this, stopped attending any, and was labeled "uncooperative."

3. Operational features of providing the services, including time lost from work, involved travel, long waits, unattractive surroundings and inconvenient hours. Also included are lack of communication, trust, and understanding between patients and personnel, and lack of time due to personnel shortages. Understandably, hostility and isolation often result from these factors.

4. Low income attitudes toward health care, resulting in differing perceptions of the health care system by patients and personnel. This leads to misinterpretation of behavior and delay or nonutilization of services.

5. Racial discrimination in provision of services. Some hospitals previously closed to black people are still not utilized to maximum potential. Many still refuse to grant black doctors staff privileges.

6. Lack of facilities and manpower. Urban slums and ghettos, as well as remote rural areas, are unattractive to most professional health personnel and their families, who choose to live and practice in upper and middle class areas. Hospitals relocate in the suburbs to escape deteriorating central city areas, and local politics often prevent establishment of area-wide, centralized medical facilities.[8]

The search for causative factors and solutions for these health problems has resulted in considerable criticism of the medical and social work professions. Many of the critical writings have been done by journalists and sociologists, but dissident reform groups within the professions have also been critical. A summary of the major criticisms of these professions indicates that they have:

1. Developed large bureaucratic organizations which are unresponsive to poor clients.

2. Preoccupied themselves with matters of economic, social and professional enhancement, rather than public service.

3. Subscribed to certain values of American society which have negative connotations for poor people.

4. Developed models of diagnosis, treatment, and communication based on "middle-class" perceptions of life, along with little or no awareness of the life circumstances and outlook of the poor.

5. Been unsuccessful in establishing effective interdisciplinary communication and coordination.

Significant amounts of research have documented these observations and have spurred medicine and social work on to draft proposals for improving practice. Specific curriculum reforms are now under consideration to improve the capabilities of practitioners who work with the poor.

The paucity of research and writings about nursing and the urban poor, however, seems to indicate that the nursing profession has not yet analyzed and evaluated itself in this regard. If so, the nursing leadership has accepted its share of the challenge without having assessed the effectiveness of its practitioners or its curriculum in the delivery of health care to the poor. It is true that nursing has been spared much of this direct and public criticism--perhaps because it is neither the leader of the team, as is medicine, nor directly responsible for the poor, as is social work. But there are a few indications that the criticism may be forthcoming.

As one observer put it, "Poverty is having a

landlady who is a public health nurse, who turns off the heat when she leaves for work in the morning and turns it back on at six when she returns."[9] The nursing profession should be more prepared to answer this criticism if it does come. It also seems clear that if nursing is a colleague profession (working with medicine and other health groups to coordinate care), then it should have its own body of research and an awareness of the research findings of the other groups.

There are some direct clues in the writings of non-nurses that nurses' perceptions of urban poverty should be further studied. Abdellah has reviewed the progress of nursing research and recommended priority areas for future research. Her priorities do not include studies of health-related aspects of poverty,[10] but she does feel that communication barriers need to be reduced among the nurse, the patient and his family.[11] Several nursing studies also reveal clues that this is an area which should be further studied.

The works of Milio and Seivwright more closely relate to the dominance of middle class values among nursing professionals. Milio found in a study of prenatal care systems that middle class values underlie the organization of community health services and provide criteria for evaluating behavior, thus making the services less effective for the poor.[12] Seivwright found that while the faculty regarded negative socioeconomic and cultural conditions as a necessary challenge to the students, most students apparently viewed this involvement with distaste. They simultaneously expressed that they felt it was most desirable and important to "accept people and situations as they are and try to help."[13] She further states:

> A plausible explanation of this... ambivalence...may be found in two factors. One is rooted in the general dilemma of the big American cities, in which low socioeconomic status, high incidence of disease and social morbidity, medical indigence, and apparent indifference to health are synonymous with minority groups in sub-cultural ghettos. The problems of these groups and approaches to them are little understood, and perhaps feared, by most Americans of other social classes. Another factor is that public health nursing, at least in the big metropolitan areas, is usually associated with providing services to minority groups. Thus, it seems that these students were confronted with a situation to which intellectually, they were positively inclined but, emotionally they reacted negatively...This apparent negativism is probably due more to respondents' own feelings of inadequacy and ability to cope, rather than to any genuine distaste for the activities involved.[14]

No studies were located which examined the perceptions of associate degree nurses regarding the life situations of the urban poor population, although there are several reasons why it would be an appropriate group to study. Nurse educators have long held that home care need not be the exclusive province of the public health nurse. Even in hospital settings public health students could practice among an urban poor population. New urban neighborhood health centers or hospital-to-horne care agencies are also likely to hire them, and the urgent nature of the problem seems to render the fine distinctions made between associate degree and other staff-level practitioners somewhat academic. Moreover, this more heterogeneous group might have more of those who could relate better culturally and socioeconomically.

Perceptual and Conceptual Background

In this time of social change, it is becoming more and more prevalent for American institutions to review the underlying values which direct their activities and the behavior of staff members. Concern for the poor has become more widespread. Yet, there are components in the national value system which may dictate insensitive behavior contradictory to religious and moral tenets also present. Changes appear to come slowly and with disruptions, since these contradictions are deeply embedded in the nation's heritage.

Institutions like the health professions might find this type of self-analysis difficult. Many practitioners lack the necessary insights provided by adequate study of political science and economic principles, disciplines lacking in the primarily clinical and technical nursing curriculum. Some knowledgeable practitioners will recall the criticism of reform-minded professionals during the recent McCarthy era. Others may be reluctant to become involved in matters of a "controversial" nature. Nevertheless, the American value system helps to define the perceptual framework of all its citizens, including practitioners. It also helps to determine the selection of curriculum offerings for future students, as well as the long-range goals of the professions.

(cont'd)

American Values vs. The Culture of Poverty

Those left out of the mainstream of society have developed adaptations of values, or countervalues in some instances. This phenomenon has often been referred to as "the culture of poverty." Attention to such life styles should tell a good deal about how and why certain groups are excluded from the mainstream and are unable to obtain adequate services. These insights can guide officials and planners to see that education, health, and social service techniques and delivery modes must be restructured if they are to be equally available to the disadvantaged poor.[15] The history and present status of health care indicates that punitive, socio-therapeutic, and individually rehabilitative methods have been tried with little success. Attention to alternatives offer opportunities for exciting programs that would reverse the growing neglect of health services for the poor.

FOOTNOTES

[1] *The Urban Planner in Health Planning.* Health Services and Mental Health Administration, Washington, D.C., 1968, p. 1.

[2] James G. Haughton, "The Two Faces of Health Care: What Is, and What Should Be," *Disability Added to Impoverishment in the Inner City: How Can the Challenge be Met?* Jewish Guild for the Blind (Symposium, September 20, 1968), New York, p. 11.

[3] H. Jack Geiger, "Health in the Troubled City," *Regional Medical Programs and their Relationships to the Urban Community and the Poor.* Arlington, Virginia, October 1, 1968, p. 11.

[4] *Ibid.*, p. 4.

[5] H. Jack Geiger, "The Endlessly Revolving Door," *American Journal of Nursing*, Vol. LXIX (November 1969), p. 2436.

[6] Albert Britten, Medical Services for Minority Groups and Their Involvement in Health Planning," *Journal of the National Medical Association*, Vol. LXI (May, 1969), p. 260.

[7] Lois J. Gordon (ed.), *Chicago Student Health Project: Summer 1967.* Chicago Student Health Project, Chicago, Illinois, 1968, p. 1.

[8] *Delivery of Health Services to the Poor: Program Analysis.* Office of the Assistant Secretary, U.S. Department of Health Education and Welfare, Washington, D.C., December 1967, pp. 32-33.

[9] Gerald Leinwand (ed.), *Poverty and the Poor.* (New York: Washington Square Press, 1968), p. 69.

[10] Faye Abdellah, "Overview of Nursing Research 1955-1968, Part I," *Nursing Research*, Vol. XIX, No. 1 (1970), p. 14.

[11] Faye Abdellah, "Overview of Nursing Research 1955-1968, Part III," *Nursing Research*, Vol. XIX, No. 3 (1970), p. 249.

[12] Nancy Milio, "Values, Social Class, and Community Health Services," *Nursing Research*, Vol. XVI, No. 1 (1967), p. 26.

[13] Mary Jane Seivwright, "The Expectations of Baccalaureate Nursing Students Concerning their Clinical Experience in Public Health Nursing." Unpublished doctoral dissertation, Department of Nursing Education, Teachers College, Columbia University, 1968, pp. 79-80.

[14] *Ibid.* p. 137.

[15] Alfred O. Kahn, *Studies in Social Policy and Planning*, New York, Russell Sage Foundation, 1969, pp. 17-19.

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